AIG
Personal Accident Claims Department
P. O. Box 25987
Shawnee Mission, KS 66225
800-551-0824 (Telephone)
866-893-8574 (Facsimile)
AHClaims@AIG.com (Email)

PROOF OF LOSS

UNDERWRITTEN BY: NUFIC

NAME OF GROUP: Nishiyamato Academy of California

POLICY NUMBER: SRG 0009147848-B

PERSONAL ACCIDENT CLAIM FORM

INSTRUCTIONS:
1.) You must have SECTION A fully completed by a designated official of the Policyholder.
2.) SECTION B is to be completed, signed and dated by the claimant or parent/guardian of claimant, if claimant is a minor.
NEW YORK FRAUD STATEMENT: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

☐ PRIMARY PLAN - benefits are payable for covered medical expenses from the first dollar without regard to payments made by other insurance up to the policy maximum.

☐ EXCESS PLAN - Eligible covered expenses will be determined after benefits have been paid by other valid and collectible insurance. You must submit your claim to your other insurance company first. When you receive their Benefit Statement (EOB) send it to us along with the itemized bills. Benefits for eligible expenses will be paid per policy terms.

The furnishing of this form, or its acceptance by the Company, must not be construed as an admission of any liability on the Company, nor a waiver of any of the conditions of the insurance contract.

SECTION A - MUST BE COMPLETED AND SIGNED BY A DESIGNATED REPRESENTATIVE OF THE POLICYHOLDER

NAME OF SCHOOL/ORGANIZATION: Nishiyamato Academy of California
NAME OF SCHOOL DISCTRICT (IF APPLICABLE):

CLAIMANT'S FULL NAME (PLEASE PRINT CLEARLY OR TYPE): Kyoka Inoue
SOCIAL SECURITY NO. MANDATORY:
DATE OF BIRTH: 06/21/2015
GENDER: MALE ☐ FEMALE ☑

WAS THE ACCIDENT RELATED TO AN ACTIVITY SPONSORED BY THE SCHOOL OR ORGANIZATION? YES ☐ NO ☐
DATE OF INJURY OR FIRST TREATMENT FOR SICKNESS: 05/26/2021
IF SICKNESS PROVIDE DATE SYMPTOMS BEGAN:

NATURE OF INJURY OR ILLNESS. (DESCRIBE FULLY, INCLUDING WHICH PART OF BODY WAS INJURED.): Broken bone of right wrist
DESCRIBE HOW (PLEASE PROVIDE ALL DETAILS) AND WHERE ACCIDENT OCCURRED: She slipped and vell from the steps of the monkey bars.

NAME OF ACTIVITY:
INDICATE THE SPORT (IF APPLICABLE):

DID ACCIDENT OCCUR:

A. WHILE CLAIMANT WAS SUPERVISED	☐ YES	☐ NO
B. DURING SPONSORED ACTIVITY	☐ YES	☐ NO
C. DURING PROGRAMMED HOURS	☐ YES	☐ NO
D. WHILE TRAVELING TO OR FROM REGULARLY SCHEDULED ACTIVITY IN A SUPERVISED GROUP	☐ YES	☐ NO

POLICYHOLDER REPRESENTATIVE (PLEASE PRINT OR TYPE): Katsuyuki Nishikawa, Principal
TITLE:
DAYTIME TELEPHONE NUMBER: 310-325-7040

SIGNATURE OF POLICYHOLDER REPRESENTATIVE:
DATE:
NAME OF SUPERVISOR:

SECTION B - MUST BE COMPLETED

DO YOU HAVE OTHER INSURANCE ☐ YES ☑ NO | IS THE OTHER INSURACE ONE OF THE FOLLOWING TYPES OF COVERAGE: ☐ GROUP (EMPLOYER) ☐ INDIVIDUAL ☐ GOVERNMENT ☐ MEDICAID

LIST NAME, ADDRESS, AND PHONE # OF OTHER INSURANCE COMPANIES UNDER WHICH CLAIMANT IS INSURED. YOU MAY ALSO SEND A COPY OF THE INSURANCE ID:
POLICY # OR ACCOUNT #:

IF CLAIMANT IS A MINOR, NAME OF CLAIMANT'S GUARDIAN/RELATIONSHIP TO CLAIMANT: Yosuke Inoue
BEST PHONE NUMBER: 908-205-2890
EMAIL ADDRESS: yinoue@msigusa.com

ADDRESS OF CLAIMANT (IF CLAIMANT IS A MINOR, NAME AND ADDRESS OF CLAIMANT'S GUARDIAN): 2300 Maple Avenue Apt #90 Torrance CA 90503
GUARDIAN'S SOCIAL SECURITY NUMBER: 812-47-3681

NAME/ADDRESS/TELEPHONE # OF EMPLOYER (IF CLAIMANT IS A MINOR, GUARDIAN'S EMPLOYER): Mitsui Sumitomo Marine Management (U.S.A.), Inc. 777 S. Figueroa St, Suite 2600 Los Angeles CA 90017
EMPLOYER'S DAYTIME TELEPHONE #: 818-942-3927

I HEREBY AUTHORIZE ANY COMMUNICATION BETWEEN THE POLICY HOLDER AND AIG AND IT'S AFFILIATES IN REGARDS TO THE ABOVE MENTIONED CLAIM AND RELATED MEDICAL EVENTS.

Signature ____________ Date ____________

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

AUTHORIZATION and ASSIGNMENT OF BENEFITS

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, governmental agency, group policyholder, insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the group policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original. I understand that I or my authorized representative may request a copy of this authorization.

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE PHYSICIAN OR SUPPLIER FOR SERVICE PERFORMED. ☐ YES ☑ NO

CLAIMANT OR PARENT/GUARDIAN'S SIGNATURE: Y Inoue
DATE: 6.11.2021